LEGISLATURE OF THE STATE OF IDAHO

Sixtieth Legislature First Regular Session - 2009

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 81

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE AND WELFARE; AMENDING SECTION 56-102, IDAHO CODE, TO REMOVE AN EXCEPTION FOR THE IDAHO STATE VETERANS HOMES, TO PROVIDE PRINCIPLES TO APPLY TO THE REIMBURSEMENT OF THE IDAHO STATE VETERANS HOMES, TO REMOVE A PROVISION FOR PAYMENT TO SKILLED CARE FACILITIES, TO PROVIDE AN ADJUSTMENT TO SKILLED CARE FACILITY PROSPECTIVE RATES WITH AN EXCEPTION, TO PROVIDE A MAXIMUM INCENTIVE PAYMENT AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 56-113, IDAHO CODE, TO PROVIDE FOR THE SAME RATE TO BE PAID TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED FOR A CERTAIN PERIOD OF TIME AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-136, IDAHO CODE, TO PROVIDE FOR THE SAME RATE TO BE PAID TO MEDICAID-COVERED PHYSICIAN AND DENTIST SERVICES FOR A CERTAIN PERIOD OF TIME, TO REVISE THE IDENTITY OF AN INDEX PUBLISHER AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-255, IDAHO CODE, TO PROVIDE NONEMERGENCY MEDICAL TRANSPORTATION BENEFITS TO CERTAIN PERSONS AND TO REMOVE NONEMERGENCY MEDICAL TRANSPORTATION BENEFITS FOR CERTAIN PERSONS; AMENDING SECTION 56-1402, IDAHO CODE, TO DEFINE NEW TERMS; AMENDING SECTION 56-1404, IDAHO CODE, TO PROVIDE FOR THE CALCULATION OF AN UPPER PAYMENT LIMIT ASSESSMENT RATE AND THE METHODOLOGY THEREFOR, TO PROVIDE FOR THE CALCULATION OF A DISPROPORTIONATE SHARE ASSESSMENT RATE FOR CERTAIN HOSPITALS AND THE METHODOLOGY THEREFOR, TO PROVIDE A LIMIT ON ASSESSMENTS FOR CERTAIN HOSPITALS AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 56-1406, IDAHO CODE, TO REVISE TIMING FOR MAKING CERTAIN PAYMENTS AND TO PROVIDE A CORRECT CODE REFERENCE; DECLARING AN EMERGENCY AND PROVIDING RETROACTIVE APPLICATION.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-102, Idaho Code, be, and the same is hereby amended to read as follows:

56-102. PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT. The following principles shall apply to the reimbursement of freestanding skilled care and ~~hospital-based~~ hospital based skilled care facilities and Idaho state veterans homes, with the exception of the nursing ~~facilities~~ facility at ~~Idaho state veterans homes and~~ state hospital south, which shall be reimbursed costs based on medicare reasonable cost provisions:

(1) Payments to facilities shall be through a prospective cost-based system which includes facility-specific case mix adjustments. Details of the methodology shall be set forth in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~ hospital based skilled care facilities. In no event shall reimbursement to any facility exceed the usual and customary charges made to private pay patients; and

(2) Each skilled care facility's case mix index shall be calculated quarterly and rates shall be adjusted based on the case mix of that facility's medicaid residents as of a certain date during the preceding quarter as specified in rule; and

(3) ~~In state fiscal year 2000, the total amount paid to skilled care facilities shall approximate the same amount in medicaid expenditures as would have been paid using the methodology in effect in state fiscal year 1999, and the percentages of medicaid funds projected to be paid to freestanding skilled care facilities and hospital based skilled care facilities shall be the same percentages that are projected to be paid using the methodology in effect during state fiscal year 1999~~ With the exception of the nursing facilities at Idaho state veterans homes, each skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from July 1, 2009, through June 30, 2010; and

(4) The cost limits used for the direct care and indirect care costs of rural ~~hospital-based~~ hospital based skilled care facilities shall be higher than the cost limits used for the direct care and indirect care costs of freestanding skilled care and urban ~~hospital-based~~ hospital based skilled care facilities; and

(5) In computing the direct care per diem rate neither medicaid-related ancillary services nor raw food shall be case-mix adjusted; and

(6) Property costs shall not be subject to a cost limitation or incentive. Property costs of freestanding skilled care facilities shall be reimbursed as described in section 56-108, Idaho Code, and property costs of urban and rural ~~hospital-based~~ hospital based skilled care facilities shall be reimbursed as described in section 56-120, Idaho Code; and

(7) Cost limits shall apply to direct care costs and indirect care costs. The cost limits shall be based on percentages above the bed-weighted median of the combined costs of both freestanding skilled care and ~~hospital-based~~ hospital based skilled care facilities; and

(8) Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined by rule; and

(9) An incentive payment shall be paid to those facilities with indirect per diem costs that are less than the established indirect care cost limit. The incentive payment is calculated by taking the difference between the cost limits and the provider's per diem indirect care cost times the incentive percentage up to a maximum of nine dollars and fifty cents ($9.50) per patient day. Freestanding skilled care and ~~hospital-based~~ hospital based skilled care facilities shall receive the same percentage incentive payments for indirect care costs but no incentive payment for direct care costs. The percentage at which the incentive payment will be set shall be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~ hospital based skilled care facilities; and

(10) A newly constructed facility shall be reimbursed at the median rate for skilled care facilities of that type (freestanding or ~~hospital-based~~ hospital based) for the first three (3) full years of operation; and

(11) A facility adding new beds will have its rates for the three (3) full years following the addition of the beds subjected to an additional reimbursement limitation. This limitation will apply beginning with the first rate setting period which uses a cost report that includes the date when the beds were added. The facility's rate will be limited to the bed-weighted average of two (2) rates: the facility's rate in effect immediately prior to the rate first subject to the limitation and the median rate for skilled care facilities of that type (freestanding or ~~hospital-based~~ hospital based) at the time the beds were added; and

(12) A facility acquired prior to the end of that facility's fiscal year will be reimbursed at the rate then in effect for that facility until the next cost report can be used for rate setting. If the department determines that the facility is operationally or financially unstable, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(13) If the department determines that a facility is located in an ~~under-served~~ underserved area, or addresses an underserved need, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(14) From July 1, 1999, through June 30, 2002, the nursing facility inflation rate plus one percent (1%) per year shall be added to the costs reported in a facility's cost report for purposes of setting that facility's rate. The inflation rate to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~ hospital based skilled care facilities; and

(15) To control the growth in the cost limits, the increase in the cost limits shall not exceed the skilled nursing facility inflation rate established by data resources, inc., or its successor, plus two percent (2%) per year for the period from July 1, 1999, through June 30, 2002. The maximum rate of growth in the cost limits to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~ hospital based skilled care facilities; and

(16) To control declines in the cost limits, the cost limits for the period from July 1, 1999, through June 30, 2002, shall not be lower than the respective cost limits effective July 1, 1999. The minimum cost limits to be used effective July 1, 2002, and the period of ~~its~~ their use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~ hospital based skilled care facilities; and

(17) Rates shall be ~~re-based~~ rebased annually. Rate setting shall be prospective with new rates effective July 1 of each year, using the principles applying to skilled care facilities set forth in this chapter and the rules promulgated pursuant to this chapter. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates will be established using the most recent audited cost report trended forward to the rate year. Rates for skilled care facilities with unaudited cost reports will be interim rates established by the department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the department no later than five (5) months from the date all information required for completion of the audit is filed with the department; and

(18) Changes of more than fifty cents (50¢) per patient day in allowable costs resulting from federal or state law or rule changes shall be treated as costs separate from the cost

limitations until such time as they become part of the data used for calculating the cost limits and in cost reports used for rate setting; and

(19) If a review of the data submitted by a facility reveals errors that result in an incorrect case mix index, the department may retroactively adjust the facility's rate and pay the facility any amount by which the facility was underpaid or recoup from the facility any amount by which the facility was overpaid; and

(20) The rates established under the principles set forth in this section shall be phased in using a combination of the reimbursement methodology in effect as of state fiscal year 1999 and the principles set forth in this section and in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing ~~hospital based~~ hospital based skilled care facilities. Effective July 1, 2001, the ~~phase in~~ phase in provisions will no longer apply and the department shall pay rates solely based on the principles set forth in this section and the applicable rules.

SECTION 2. That Section 56-113, Idaho Code, be, and the same is hereby amended to read as follows:

56-113. INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED. (1) Services provided by intermediate care facilities for the mentally retarded, with the exception of state operated facilities, shall be paid in accordance with the provisions of this section, and not as provided in any other section of this chapter, unless otherwise provided in this section. State operated facilities shall be reimbursed costs based on medicare reasonable cost provisions.

(2) Except as otherwise provided in this section, intermediate care facilities for the mentally retarded shall remain at the rate paid in state fiscal year 2009 through June 30, 2010. Thereafter, intermediate care facilities for the mentally retarded shall be reimbursed based on a prospective rate system without retrospective settlement effective October 1, 1996. In no event, shall payments to this class of facility exceed, in the aggregate, the amount which would be reimbursed using medicare cost reimbursement methods as defined in the medicare provider reimbursement manual (HCFA - pub. 15).

(3) The prospective rate shall consist of the following components:

(a) A component for reasonable property costs which shall be computed using the property rental rate methodology set forth in section 56-108, Idaho Code, with the exceptions that the base rate shall exclude major moveable equipment and grandfathered rates will not apply. The initial base rate shall be eight dollars and ninety-four cents ($8.94) for facilities that accommodate residents in wheelchairs and five dollars and eighty-one cents ($5.81) for facilities that cannot accommodate residents in wheelchairs. The rates shall be adjusted annually as provided in section 56-108, Idaho Code; and

(b) A component for forecasted reasonable day treatment costs which shall be subject to a per patient day limit as provided in rule; and

(c) A component for all other allowable costs as determined in accordance with department rules which shall be subject to a limitation based on a percentage of the forecasted median for such costs of intermediate care facilities for the mentally retarded, excluding state operated facilities; and

(d) A component that provides an efficiency increment payment of twenty cents (~~$.~~20¢) for each one dollar ($1.00) per patient day that the facility is under the limit described in

subsection (3)(c) of this section up to a maximum payment of three dollars ($3.00) per patient day.

(4) The director may require retrospective settlement as provided by rule in limited circumstances including, but not limited to:

(a) The facility fails to meet quality of care standards; or

(b) The facility is new or operated by a new provider, until such time as a prospective rate is set; or

(c) The prospective rate resulted from fraud, abuse or error.

(5) The director shall have authority to provide by rule, exceptions to the limitations described in subsection (3) of this section.

(6) The director shall promulgate the rules necessary to carry out the provisions of this section.

SECTION 3. That Section 56-136, Idaho Code, be, and the same is hereby amended to read as follows:

56-136. PHYSICIAN AND DENTIST REIMBURSEMENT. (1) The rate of reimbursement for all medicaid-covered physician and dentist services rendered to medicaid recipients shall remain at the rate paid in state fiscal year 2009 through June 30, 2010. Thereafter, the reimbursement rate for all medicaid-covered physician and dentist services rendered to medicaid recipients shall be adjusted each fiscal year. Each fiscal year adjustment shall be determined by the director and shall equal the year over year inflation rate forecasted as of the midpoint of the fiscal year by the all item, goods and services index in the pacific northwest as published by ~~data resources incorporated~~ global insights, inc., or its successor. Such forecast index shall be the last published forecast prior to the start of the fiscal year. Provided however, an adjustment may exceed the index rate cited in this section at the discretion of the legislature.

(2) Actual payments made by the director to each physician and dentist shall not exceed the usual and customary charges made to private pay patients.

(3) For the purposes of this section:

(a) "~~Physican~~Physician" means a person licensed to practice medicine pursuant to chapter 18, title 54, Idaho Code.

(b) "Dentist" means a person licensed to practice dentistry pursuant to chapter 9, title 54, Idaho Code.

(4) The amount to be paid under the provisions of this section shall in no event exceed any limitations imposed by federal law or regulation.

SECTION 4. That Section 56-255, Idaho Code, be, and the same is hereby amended to read as follows:

56-255. MEDICAL ASSISTANCE PROGRAM – SERVICES TO BE PROVIDED. (1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary and in accordance with federal law and regulation, Idaho law and department rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho

Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age adults with no special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found; and

(c) Cost-sharing required of participants. Participants in the low-income children and working-age adult group are subject to the following premium payments, as stated in department rules:

(i) Participants with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guideline are not required to pay premiums; and

(ii) Participants with family incomes above one hundred thirty-three percent (133%) of the federal poverty guideline will be required to pay premiums in accordance with department rule.

(3) Specific health benefits for persons with disabilities or special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found;

(c) Case management services as defined in accordance with section 1905(a)(19) or section 1915(g) of the social security act; and

(d) Mental health services, including:

(i) Inpatient psychiatric facility services whether in a hospital, or for persons under age twenty-two (22) years in a freestanding psychiatric facility, as permitted by federal law, in excess of those limits in department rules on inpatient psychiatric facility services provided under subsection (5) of this section;

(ii) Outpatient mental health services in excess of those limits in department rules on outpatient mental health services provided under subsection (5) of this section; and

(iii) Psychosocial rehabilitation for reduction of mental disability for children under the age of eighteen (18) years with a serious emotional disturbance (SED) and for severely and persistently mentally ill adults, aged eighteen (18) years or older, with severe and persistent mental illness;

(e) Long-term care services, including:

(i) Nursing facility services, other than services in an institution for mental diseases, subject to participant cost-sharing;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require nursing facility level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including an option for self-determination, which will enable individuals to have greater freedom to manage their own care; and

(iii) Personal care services in a participant's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse;

(f) Services for persons with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined in accordance with section 1902(a)(31) of the social security act to be in need of such care, including such services in a public institution, or distinct part thereof, for the mentally retarded or persons with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require an intermediate care facility for the mentally retarded (ICF/MR) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including an option for self-determination, which will enable individuals to have greater freedom to manage their own care; and

(iii) Developmental services. The department shall pay for rehabilitative services, including medical or remedial services provided by a facility that has entered into a provider agreement with the department and is certified as a developmental disabilities agency by the department;

(g) Home health services, including:

(i) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area;

(ii) Home health aide services provided by a home health agency; and

(iii) Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility;

(h) Hospice care in accordance with section 1905(o) of the social security act;

(i) Specialized medical equipment and supplies; ~~and~~

(j) Medicare cost-sharing, including:

(i) Medicare cost-sharing for qualified medicare beneficiaries described in section 1905(p) of the social security act;

(ii) Medicare part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the social security act;

(iii) Medicare part B premiums for specified low-income medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the social security act; and

(iv) Medicare part B premiums for qualifying individuals described in section 1902(a)(10)(E)(iv) and subject to section 1933 of the social security act; and

(k) Nonemergency medical transportation.

(4) Specific health benefits for persons over twenty-one (21) years of age who have medicare and medicaid coverage include:

(a) All services described in subsection (5) of this section, other than if provided under the federal medicare program;

(b) All services described in subsection (3) of this section, other than if provided under the federal medicare program; ~~and~~

(c) Other services that supplement medicare coverage; and

(d) Nonemergency medical transportation.

(5) Benefits for all medicaid participants, unless specifically limited in subsection (2), (3) or (4) of this section include the following:

(a) Health care coverage including, but not limited to, basic inpatient and outpatient medical services, and including:

(i) Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere;
(ii) Services provided by a physician or other licensed practitioner to prevent disease, disability and other health conditions or their progressions, to prolong life, or to promote physical or mental health; and
(iii) Hospital care, including:
1. Inpatient hospital services other than those services provided in an institution for mental diseases;
2. Outpatient hospital services; and
3. Emergency hospital services;
(iv) Laboratory and x-ray services;
(v) Prescribed drugs;
(vi) Family planning services and supplies for individuals of child-bearing age;
(vii) Certified pediatric or family nurse practitioners' services;
(viii) Emergency medical transportation;
(ix) Mental health services, including:
1. Outpatient mental health services that are appropriate, within limits stated in department rules; and
2. Inpatient psychiatric facility services within limits stated in department rules;
(x) Medical supplies, equipment, and appliances suitable for use in the home; and
(xi) Physical therapy and related services;
(b) Primary care case management;
(c) Dental services, and medical and surgical services furnished by a dentist in accordance with section 1905(a)(5)(B) of the social security act;
(d) Medical care and any other type of remedial care recognized under Idaho law, furnished by licensed practitioners within the scope of their practice as defined by Idaho law, including:
(i) Podiatrists' services;
(ii) Optometrists' services;
(iii) Chiropractors' services; and
(iv) Other practitioners' services, in accordance with department rules;
(e) Services for individuals with speech, hearing and language disorders, provided by or under the supervision of a speech pathologist or audiologist;
(f) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;
(g) Services provided by essential providers, including:
(i) Rural health clinic services and other ambulatory services furnished by a rural health clinic in accordance with section 1905(l)(1) of the social security act;
(ii) Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 1905(l)(2) of the social security act;
(iii) Indian health services;
(iv) District health departments; and

(v) The family medicine residency of Idaho and the Idaho state university family medicine residency;

(h) Any other medical care and any other type of remedial care recognized under state law, specified by the secretary of the federal department of health and human services; and

(i) ~~Nonemergency medical transportation; and~~

~~(j)~~ Physician, hospital or other services deemed experimental are excluded from coverage. The director may allow coverage of procedures or services deemed investigational if the procedures or services are as cost-effective as traditional, standard treatments.

SECTION 5. That Section 56-1402, Idaho Code, be, and the same is hereby amended to read as follows:

56-1402. DEFINITIONS. As used in this chapter:

(1) "Department" means the department of health and welfare.

(2) "Disproportionate share hospital" means a hospital that serves a disproportionate share of medicaid low-income patients as compared to other hospitals as determined by department rule.

(3) "Governmental entity" means and includes the state and its political subdivisions.

(~~2~~4) "Hospital" is as defined in section 39-1301(a), Idaho Code.

(~~3~~5) "Political subdivision" means a county, city, municipal corporation or hospital taxing district and, as used in this chapter, shall include state licensed hospitals established by counties pursuant to chapter 36, title 31, Idaho Code, or jointly by cities and counties pursuant to chapter 37, title 31, Idaho Code.

(~~4~~6) "Private hospital" means a hospital that is not owned by a governmental entity.

(~~5~~7) "Upper payment limit" means a limitation established by federal regulations, 42 CFR 447.272 and 42 CFR 447.321, that disallows federal matching funds when state medicaid agencies pay certain classes of hospitals an aggregate amount for inpatient and outpatient hospital services that would exceed the amount that would be paid for the same services furnished by that class of hospitals under medicare payment principles.

SECTION 6. That Section 56-1404, Idaho Code, be, and the same is hereby amended to read as follows:

56-1404. ASSESSMENTS. (1) All hospitals, except those exempted under section 56-1408, Idaho Code, shall make payments to the fund in accordance with this chapter. Subject to section 56-1410, Idaho Code, an annual assessment on both inpatient and outpatient services is determined for each qualifying hospital for state fiscal years 2009, 2010 and 2011, in an amount calculated by multiplying the rate, as set forth in subsections (2)(b) and (3)(b) of this section, by the assessment base, as set forth in subsection (~~4~~5) of this section.

(2) (a) The department shall calculate the private hospital upper payment limit gap for both inpatient and outpatient services. The upper payment limit gap is the difference between the maximum allowable payments eligible for federal match, less medicaid payments not financed using hospital assessment funds. The upper payment limit gap shall be calculated separately for hospital inpatient and outpatient services. Medicaid disproportionate share payments shall be excluded from the calculation.

(~~3~~b) The department shall calculate the upper payment limit assessment rate for state fiscal years 2009, 2010 and 2011 to be the percentage that, when multiplied by the assessment base as defined in subsection (~~4~~5) of this section, equals the upper payment limit gap determined in ~~subsection~~ paragraph (~~2~~a) of this subsection~~, but is not greater than one and one-half percent (1.5%)~~.

(3) (a) The department shall calculate the disproportionate share allotment amount to be paid to private in-state hospitals.

(b) The department shall calculate the disproportionate share assessment rate for private in-state hospitals to be the percentage that, when multiplied by the assessment base as defined in subsection (5) of this section, equals the amount of state funding necessary to pay the private in-state hospital disproportionate share allotment determined in paragraph (a) of this subsection.

(4) For private in-state hospitals, the assessments calculated pursuant to subsections (2) and (3) of this section shall not be greater than two and one-half percent (2.5%) of the assessment base as defined in subsection (5) of this section.

(5) The assessment base shall be the hospital's net patient revenue for the applicable period. "Net patient revenue" for state fiscal year 2009 shall be determined using the most recent data available from each hospital's fiscal year 2004 medicare cost report on file with the department on June 30, 2008, without regard to any subsequent adjustments or changes to such data. Net patient revenue for state fiscal year 2010 shall be determined using the most recent data available for each hospital's fiscal year 2005 medicare cost report on file with the department on June 30, 2009, without regard to any subsequent adjustments or changes to such data. Net patient revenue for state fiscal year 2011 shall be determined using the most recent data available from each hospital's fiscal year 2006 medicare cost report on file with the department on June 30, 2010, without regard to any subsequent adjustments or changes to such data.

SECTION 7. That Section 56-1406, Idaho Code, be, and the same is hereby amended to read as follows:

56-1406. INPATIENT AND OUTPATIENT ADJUSTMENT PAYMENTS. All hospitals, except those exempted under section 56-1408, Idaho Code, shall be eligible for inpatient and outpatient adjustments as follows:

(1) For state fiscal year 2009, the inpatient upper payment limit gap for private hospitals shall be divided by medicaid inpatient days for the same hospitals from calendar year 2007 to establish an average per diem adjustment rate. Each hospital shall receive an annual payment that is equal to the average per diem adjustment rate multiplied by the hospital's calendar year 2007 medicaid inpatient days. For purposes of this section, "hospital medicaid inpatient days" are days of inpatient hospitalization paid for by the Idaho medical assistance program for the applicable calendar year. For fiscal year 2010, calendar year 2008 inpatient hospital medicaid days shall be utilized to determine the hospital inpatient adjustment payment. For state fiscal year 2011, calendar year 2009 hospital medicaid inpatient days shall be utilized to determine the hospital inpatient adjustment payment. In the event that either the inpatient upper payment limit gap for private hospitals or the available hospital assessment funding is lower than anticipated, the department shall apply an across-the-board factor such that the inpatient payment adjustments are maximized, financed entirely from hospital assessment funding, and do not exceed the Idaho inpatient upper payment limit for private hospitals. Payments shall

be made no later than seven (7) days after the due date for the hospital assessment required in section 56-1404, Idaho Code.

(2) For state fiscal year 2009, the outpatient upper payment limit gap for private hospitals shall be divided by medicaid outpatient hospital reimbursement for the same hospitals from calendar year 2007 to establish an average percentage adjustment rate. Each hospital, except those exempt under section 56-1408, Idaho Code, shall receive an annual payment that is equal to the average percentage adjustment rate multiplied by the hospital's calendar year 2007 hospital medicaid outpatient reimbursement. For purposes of this section, "hospital outpatient reimbursement" is reimbursement for hospital outpatient services paid for by the Idaho medical assistance program for the applicable calendar year. For state fiscal year 2010, calendar year 2008 hospital medicaid outpatient reimbursement shall be utilized to determine the outpatient hospital adjustment payment. For state fiscal year 2011, calendar year 2009 hospital medicaid outpatient reimbursement shall be utilized to determine the outpatient hospital adjustment payment. In the event that either the outpatient upper payment limit gap for private hospitals or the available hospital assessment funding is lower than anticipated, the department shall apply an across-the-board factor, such that outpatient adjustment payments are maximized, financed entirely from hospital assessment funding, and do not exceed the Idaho outpatient upper payment limit for private hospitals. Payments shall be made no later than ~~seven~~ thirty (~~7~~30) days after the ~~due date for~~ receipt of the last deposit of the hospital assessments required in section 5~~4~~6-1404, Idaho Code.

SECTION 8. An emergency existing therefor, which emergency is hereby declared to exist, Section 4 of this act shall be in full force and effect on and after passage and approval, and retroactively to April 1, 2009.